SOUTH DAKOTA BOARD OF NURSING

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IN THE MATTER OF THE LICENSURE PROCEEDINGS	:	
	:	**DOH 19-05**
RE: JESSICA GORECKI, RN,	:	
License No.: R050924	:	**ORDER OF SUSPENSION**
Licensee.	:	

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The South Dakota Board of Nursing, having separately entered Findings of Fact and Conclusions of Law following a contested case hearing before the Board on April 16, 2019, and having verbally ordered on the 16th day of April, 2019, to suspend Licensee's license, hereby issues Licensee this Order of Suspension for violation of SDCL § 36-9-49 consistent with the Board's Findings of Fact and Conclusions of Law, incorporated herein by reference.

It is hereby ORDERED:

1. Licensee's license to practice as a registered nurse in the State of South Dakota is hereby indefinitely suspended.

2. Licensee is hereby notified that any practice of or holding herself out as a registered nurse during the term of this suspension is in violation of SDCL § 36-9-68.

Dated this 21ST day of May, 2019.

SOUTH DAKOTA BOARD OF NURSING

Gloria Damgaard

Gloria Damgaard, RN, MS
Executive Director

SOUTH DAKOTA BOARD OF NURSING

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IN THE MATTER OF THE LICENSURE PROCEEDINGS	:	
	:	**DOH 19-05**
RE: JESSICA GORECKI, RN,	:	
License No.: R050924	:	**FINDINGS OF FACT AND CONCLUSIONS OF LAW**
Licensee.	:	
	:	

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The South Dakota Board of Nursing ("Board") noticed a contested case hearing in the above licensure proceedings, specifically for the Complaint and Notice of Hearing dated February 13, 2019, to be held on April 16, 2019, at 9:00 a.m.

The South Dakota Board of Nursing presided over the proceedings, along with Administrative Law Judge Catherine Williamson, Office of Hearing Examiners. Licensee Jessica Gorecki, RN, failed to appear at the hearing. Michele Munson, the attorney prosecuting the licensing matter, presented evidence on behalf of the Board of Nursing. The proceeding was transcribed by a court reporter.

At the conclusion of the hearing, the Board considered the testimony from witnesses, exhibits offered during the hearing, argument of counsel, as well as the entire record before the Board. After deliberations, the Board entered a verbal order to suspend Licensee's license.

Pursuant to SDCL 1-26-25, the Board issues its final decision in writing through these written Findings of Fact and Conclusions of Law as well as a separate written Order issued pursuant to these Findings of Fact and Conclusions of Law.

Being charged with the statutory obligation to protect the public health, safety and welfare set forth in ARSD 20:48:04:01, *et al.*, including the protection of the public from unsafe nursing practices and practitioners, the Board hereby makes the following:

FINDINGS OF FACT

1. Jessica Gorecki, RN ("Licensee") is licensed to practice as a nurse in the State of South Dakota and holds license number R050924. She is also licensed to practice as a nurse in the State of Minnesota.

2. In November 2018, the Board received a complaint regarding Licensee from Avera McKennan Hospital, alleging Licensee had the highest narcotic dispensing rate of all her peers and they had concerns regarding Licensee's narcotic wasting practices. Licensee's employer had concerns regarding Licensee diverting narcotic medications.

3. After the Board received the complaint regarding Licensee, Board staff began investigating the complaint.

4. Board staff sent a written notice to the Licensee regarding setting up an informal meeting on November 5, 2018. Board staff sends the notice to the Licensee's address maintained in the Board's database. Each Licensee is required to provide and update the Board with his or her current address.

5. Licensee did not respond to Board staff's written notice of the complaint.

6. Board staff sent a second notice to Licensee via both the United State Postal Service and Certified Mail on December 28, 2018.

7. Board staff also made two attempts to contact the Licensee by telephone.

8. Again, Licensee did not respond to the telephone calls. Board staff called Licensee at her telephone number maintained in the Board's database, 253-397-0421, on December 20, 2018 and December 28, 2018. This phone number was also listed on Licensee's resume. Licensee's message stated that her phone number had been disconnected.

9. Licensee is a traveling nurse. She started at Avera McKennan on July 30, 2018.

10. On October 23, 2018, the Nurse Educator and Nurse Manager at Avera were notified by two separate registered nurses that they had concerns about Licensee's narcotic wasting practices exhibited on October 22 and October 23, 2018.

11. Two registered nurses reported that they were asked to waste hydromorphone from an open package after a significant time delay from when the medication was removed from Pyxis, and Licensee's handling and administration of the medication had not been witnessed.

12. In addition, Licensee worked on October 23, 2018, from 7:30 a.m. to 7:19 p.m. That same night, around 10:30 p.m., the Nurse Manager was notified by the night shift registered nurse that Licensee had called in wanting to come back to work at 11:00 p.m., in response to a request from the night shift registered nurse for additional staff. The Nurse Manager decided that Licensee should not come back. When this was reported to Licensee, the Licensee was significantly irritable.

13. The next day, October 24, 2018, the Nurse Manager reviewed the records reported by the two registered nurses regarding Licensee. The Nurse Manager also noted concerns and questions regarding Licensee's administration and medication handling practices.

14. The Nurse Manager also noted a report on October 11, 2018, regarding Licensee being irritable with another registered nurse regarding floating needs, and the unit supervisor had experienced difficulty contacting Licensee on October 19, 2018, to confirm Licensee's schedule.

15. Upon reviewing Pyxis activity and documentation with the EMR, Licensee had an extremely high utilization rate compared to her peers within the orthopedic unit at Avera McKennan. From October 1, 2018 through October 24, 2018, Licensee had 227 dispensing transactions, with the next highest dispense rate for the month of October 2018 within all of Avera McKennan at 145. Licensee's utilization of hydromorphone 1 mg injectable syringes from the same time frame was 85 syringes, with the next highest nurse on the orthopedic unit at 55. Licensee's utilization of hydrocodone/APAP 5/325 was 56 tabs, and the next highest nurse on the orthopedic unit was 22 tabs.

16. The specific patient dispensing and administration records also confirmed Licensee's practices were significantly higher than her peers. On multiple occasions, Licensee had administered hydromorphone 1 mg intravenously with hydrocodone/APAP, which is concerning. In addition, Licensee commonly dispensed and administered pain medications when beginning her shift and prior to ending her shifts. There were frequent occurrences of her dispensing medications from Pyxis with a delay in administration of over an hour. With range prescription orders, she almost always gave the highest dose and had no waste transactions for partial doses of hydromorphone. Licensee had 5 full syringe waste doses documented in October 2018.

17. The specific patient dispensing and administration records also confirmed many occurrences of Licensee dispensing controlled substances for multiple patients within the same Pyxis login, which is an extremely rare practice. When utilizing the hydromorphone range order of .5-1 mg every two hours as needed for pain, Licensee almost always administered 1 mg, which was different than her nursing peers. Licensee consistently administered pain medications more frequently than indicated and did not wait the full two or four hours in between PRN doses.

18. On November 2, 2018, Avera terminated Licensee's employment. Avera terminated Licensee "for cause due to suspected drug diversion."

19. On January 24, 2019, Licensee e-mailed another Board staff member, other than the Board investigator. Licensee stated, "I am wondering if you could e-mail me all the infi [sic] you can regarding the investigation that is taking place on me."

20. The staff member immediately forwarded the e-mail from Licensee to the Board staff investigator for handling. Board staff responded to Licensee within 30 minutes of Licensee's e-mail to the other BON staff member. Staff told Licensee, "I cannot mail any documents. If you would like to schedule a time to come to the Board office and discuss the complaint, the documents can be reviewed at that time. Please contact with your availability. Please provide a phone number you can be reached at, the number you previously provided has been disconnected. Have you received the mail sent to the address you provided?"

21. As of the date of the hearing, Licensee did not otherwise respond to the Board staff regarding the complaint.

22. No evidence exists as to whether Licensee is currently practicing in this state or elsewhere. Licensee has not responded or otherwise cooperated with the investigation or disciplinary proceedings as of the date of the hearing.

From the foregoing findings of fact, the Board draws the following:

CONCLUSIONS OF LAW

1. That the Board has jurisdiction and authority over this matter pursuant to ARSD 20:48:04:01.

2. Pursuant to SDCL § 36-9-69, it shall be necessary to prove in any prosecution for any violation of this chapter only a single act prohibited by law or a single holding out or an attempt without proving a general course of conduct in order to constitute a violation.

3. Based upon the above clear and convincing findings of fact, the Board concludes that Licensee has engaged in conduct in violation of SDCL § 36-9-49(4), in that Licensee has committed a drug related act, specifically diversion of prescription medications, that interferes with Licensee's ability to practice nursing safely.

4. Based upon the above clear and convincing findings of fact, the Board concludes that Licensee engaged in conduct in violation of SDCL § 36-9-49(5), in that Licensee has negligently, willfully, or intentionally acted in a manner inconsistent with the health or safety of a person entrusted to Licensee's care.

5. Based upon the above clear and convincing findings of fact, the Board concludes Licensee engaged in conduct in violation of SDCL § 36-9-49(7), in that Licensee violated provisions of Chapter 36-9 and/or the rules promulgated under it.

6. Based upon the above clear and convincing findings of fact, the Board concludes Licensee engaged in conduct in violation of SDCL § 36-9-49(10), in that Licensee engaged in unsafe nursing practice, substandard care, or unprofessional or dishonorable conduct.

7. The Board has a statutory obligation to protect the public health, safety and welfare set forth in SDCL § 36-9-1.1, including the protection of the public from unsafe nursing practices and practitioners.

8. Under SDCL 1-26-29, if the Board finds that public health, safety, or welfare require action, including suspension of a license, suspension may be ordered even on an emergency basis.

9. The Board concludes that, given the evidence presented at the hearing, there is clear and convincing evidence that Licensee engaged in drug diversion during her employment as a nurse that endangers the health and safety of those persons who are or will be entrusted to Licensee's care.

10. The Board concludes that disciplinary action, including specifically suspension of Licensee's license, is appropriate due to Licensee's violations of SDCL 36-9-49 (4), (5), (7), and/or (10).

11. The South Dakota Board of Nursing, at the hearing on the 16th day of April, 2019, by a vote of 8-0, decided based on these Findings of Fact and Conclusions of Law to iss an Order Suspending License. Such Letter of Reprimand shall be separately entered.

Dated this 21st day of May, 2019.

SOUTH DAKOTA BOARD OF NURSING

Gloria Damgaard

Gloria Damgaard, RN, MS
Executive Director